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RETENTION

OF THE

PLACENTA AFTER ABORTION.

—BY—

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RETENTION OF THE PLACENTA AFTER ABORTION.

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It is very difficult to determine the frequency with which abortions occur. Hegar states that at least one abortion occurs to every eight or ten full time deliveries. Devilliers says, the proportion is one to every three or four. Whitehead states the proportion to be about one to seven, and says, that while thirty-seven out of every hundred mothers experience abortion before they attain the age of 30, the percentage of those living on in wedlock to the menopause who are subject to this accident rises as high as eighty-seven.

In cases of abortion where the stage of expectancy is clearly over, there are two main indications to be fulfilled, namely, first, to stop the hemorrhage, and second, to procure the entire removal of the ovum and its placental attachments.

If the hemorrhage be severe and the ovum not already passed and the cervix not dilated, the best plan is to plug the cervix with a sponge tent as large as it will admit of, or three or

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This paper on Retention of the Placenta after Abortion, is offered as a supplement to a paper on Partial Retention of the Placenta after Labor, read before this society in February, 1878 (and published in the MARYLAND MEDICAL JOURNAL, of March, 1879, page 276).

four small ones will answer the same purpose. These should always be covered with thin rubber or gold-beaters skin, and a syringe full of water injected into the tents to insure their full dilatation. The vagina then should be tamponed with cotton, moistened with carbolized glycerine. In twelve hours the cervix will be sufficiently dilated to allow the passage of the ovum, and at the same time allow of the easy removal of the placenta, and a thorough digital intra-uterine examination to see that no portions of it are allowed to remain.

If the ovum be already passed and hemorrhage continue the same plan may be followed, or Hanks' Hard Rubber dilators for rapid dilation of the uterus may be used, by which the uterus may be emptied without delay. In cases where the placenta has remained several days, and septicæmic symptoms have set in, rapid dilation with Hanks' dilators is to be preferred to all other means of dilating the cervix. Barnes' and Molesworth's dilators are almost useless for dilating a uterus before the seventh month of pregnancy. And in a case of septicæmic poisoning, such as will be mentioned further on, the patient would almost certainly die before dilatation could be secured if sponge tents were relied upon.

Having formed in our mind a clear idea as to what has to be done in order to secure the entire detachment of the retained ovum and all its fragments, viz: We have to pass one or more fingers into the uterus to explore its entire cavity, to separate from its walls any adherent portion of the ovum, and then to extract the separated mass. We may render the uterine cavity completely accessible to the exploring finger by the bi-manual method, but still better by Simpson's method of seizing the anterior lip with a double tenaculum forceps, one of the blades grasps the vaginal aspect of the front wall of the cervix as high up as the roof of the vagina, the other at a corresponding level within the cervical canal. The uterus is capable of being pulled considerably down without any injury to its ligaments, or laceration. It may be pulled down with the right hand and kept fixed with it, while the fingers of the left pass into the cavity and explore and evacuate it. The cavity of the uterus is thus brought within full reach of the fingers, and we

can,—and in all those cases of imperfect delivery in the early months we ought to,—control the emptying of the cavity from fundus to os. The manipulations necessary to secure a satisfactory result cause some suffering, though not to a great degree, which we can always save the patient by bringing her under the influence of chloroform.

The following cases will be referred to, to show how long a hemorrhage may go on under medical treatment and how easily and readily the uterus is emptied and the hemorrhage stopped when the proper measures are adopted.

CASE I. Mrs. W., the mother of six children, sent to my office late on the night of January 7th 1877, for a prescription for something to stop a hemorrhage from the uterus, the messenger stated that she had had a fall on the ice about a week before and that pains set in on the following day, and that a miscarriage had taken place on the 5th, but that the hemorrhage still continued and was increasing, I prescribed Squibb's fl. ext. ergot ʒss. every hour. After prescribing all the usual remedies for seven days and using the vaginal tampon without result, I finally concluded to plug the cervix with a sponge-tent as the patient had now become so weak that she could stand no further loss of blood. In the afternoon I removed the tent and introduced two fingers into the uterus and detached a small piece of placental tissue which was still adherent to the uterus. After this the hemorrhage ceased and the patient, though extremely weak, made a rapid recovery.

CASE II. Mrs. H., aged 42, married, youngest child six years old, was taken with violent pains in the abdomen soon after eating a hearty dinner on September 19, 1878. Thinking that she had an attack of cholera morbus, she used the usual domestic remedies for this complaint. About 5 o'clock in the evening she had violent straining and purging followed by a bloody discharge from the vagina.

This discharge continuing, I saw her about 9 o'clock at night —she stated that she had no symptoms of pregnancy—that her menses had been very irregular for the past eighteen months—she also stated that nothing resembling a fœtus had passed from her. Upon examination, the uterus was enlarged, the cervix

slightly patulous. Thinking that she was about to have a miscarriage, I ordered half drachm doses of fl. ext. viburnum prunifolium every half hour until the hemorrhage ceased. On September 20th, the flow still continued, the fl. ext. ergot was given, but did not diminish the discharge, and on the 23rd the discharge became so offensive that I concluded that she had had an abortion before I had seen her on the 19th. Putting her under the influence of chloroform, I dilated the cervix with Hank's hard rubber dilators, and introduced two fingers of the right hand into the uterus and found a portion of placental tissue firmly adherent to the left side of the uterus. I could not succeed in detaching it until I introduced the left finger with which it was readily separated, the right finger passed above its attachment to the uterus, but the left finger being more readily passed under it lifted it from its attachment.

The use of placental forceps, curettes and the various instruments that have been devised for the removal of retained placenta are much more uncertain, and less safe than the finger and hand.

Of course the more completely the cervix is dilated before any attempt is made for the removal of the adherent placental portion, the more readily and safely it can be accomplished.

Case III.—Annie C., aged 22, unmarried, sewing machine operator, was seen for the first time December 4th, 1879. The lady with whom she lived stated that she had been having considerable hemorrhage for several days, and that her womb was entirely down. Upon examination the cervix was found to be patulous admitting the index finger, and the uterus enlarged. The girl denied having passed anything but blood, and also denied being pregnant. Each day she stated that the hemorrhage was checking and that she felt much better, although it was very apparent that she was getting decidedly worse. She insisted that the hemorrhage was only her courses which were always profuse and lasted nearly a week.

Her temperature and pulse gradually rose until on the tenth her temperature was 103° and her pulse 140, and on the following morning more decided septicæmic symptoms with severe chills set in. Believing that an abortion had taken place, I de-

cided to explore the uterus without further delay. With the assistance of Dr. George F. Adams, she was put under chloroform, the uterus dilated with Hanks' dilators, and I succeeded with the finger and curette in detaching a large piece of placental tissue about an inch and a half long and an inch wide, which was undergoing decomposition in the uterus. About ℥i. of sloughy placental debris which was extremely offensive was removed by wiping out the uterus with absorbent cotton, and the whole interior of uterus was sponged out with very hot water, and then thoroughly mopped out with Churchill's tincture of iodine. When she was put back to bed she had a severe chill, but after remaining extremely ill for three days she commenced to improve and slowly convalesced. Poultices were kept over her abdomen and large doses of quinine with sufficient opium to allay the pain were kept up until about a week after the removal of the portion of retained placenta.

The girl afterwards acknowledged that the fœtus had passed from her the day before I saw her, and that she had got a servant to empty it in the sink without the knowledge of the lady of the house, and that she had induced the latter to believe that the presenting fœtal membranes was a falling of the womb.

In this case there was a deep laceration of the cervix, at the time the placental portion was removed, and so long as the discharge continued it was impossible for this to unite.

From the history of a large number of cases of laceration of the cervix which came under my care at the Baltimore Special Dispensary while in charge of the department of diseases of women and also in my private practice, I am led to believe that lacerations of the cervix and the accompanying conditions of subinvolution and cellulitis are more frequently caused by retention of placental remains in the uterus, than as the result of the severity of the direct injury, for we know that two freshly torn surfaces will generally unite when kept in apposition, and further that in the operation for bilateral incision of the cervix the difficulty is that the surfaces will frequently unite in spite of the efforts made to keep them asunder.

And again in several cases of abortion and after labor, where I

have been fully satisfied that all placental structure and all clots were entirely removed and the uterus firmly contracted; I have in some of these cases had an opportunity of examining the uterus after the lapse of a month or six weeks, and in such, the most accomplished expert could not, from the appearance of the cervix, have known whether the woman had ever been pregnant.

There is also another class of cases which we meet with, one, two or three years, or even longer after an abortion. These cases present all the symptoms of chronic uterine disease, such as menorrhagia, leucorrhœa, backache, &c., &c., they are generally improved by any intelligent plan of treatment. Tonics benefit them for awhile, and local treatment, such as vaginal douches, pessaries, applications of iodine, &c., sometimes improve them very much, but within a month or two after leaving off treatment, they relapse, and are as bad as before. This condition is frequently, I believe, a remote result of partial retention of the placenta. In these cases, if the dull wire curette be used it will generally be found that the former placental site is studded over with numerous little cysts from the size of a shot to that of a pea, when removed with the curette they will float upon water, and have the appearance of small air bubbles. After they are thoroughly removed a few applications of Churchill's iodine may be made, although, generally even this is unnecessary.

This condition is very frequently accompanied with cellulitis, and sometimes with laceration of the cervix; the former should be cured before the curette is used, the latter afterwards.

As there is so little information upon this subject contained in any of the text books, or systematic works on obstetrics, I have appended the following references.

1. On the complete evacuation of the uterus after abortion by Prof. A. R. Simpson, *Ob. Jour. Great Brit. and Ireland*, Vol. iv, p. 179.

2. Pyæmia with clinical history of septicæmia, by Dr. Loomis, *N. Y. Med. Record*, January 10, 1880, p. 43, at the autopsy the uterus contained a fragment of placenta.

3. A clinical lecture on the Treatment of Leucorrhœa, &c.,

with history of a case of retained placenta, &c., by Dr. T. Gaillard Thomas, New York, *Med. Rec.*, Jan. 24, 1880, p. 81.

4. A case of Septicæmia Following an Abortion, by Dr. Isaac Oppenheimer, *N. Y. Med. Rec.*, July 7, 1879, p. 534.

5. The Treatment of Hemorrhage in Abortion, by W. T. Lusk, *N. Y. Med. Rec.*, March 8, 1879, p. 220, and discussion by Dr. Barker 232.

6. A Case of Abortion at three and one-half months in which the placenta was probably retained, by Dr. David Young, of Florence, *Obst. Jour. Great Brit. and Ireland*, Vol. vi, p. 24.

7. Hanks' Hard Rubber Dilators for the rapid dilatation of the uterus during pregnancy with discussion upon the same, by Drs. Noeggerath, Chamberlain and Thomas, and the camparative value of Hanks', Molesworth's and Barnes' dilators, *Trans. N. Y. Obst. Society*,—in the *Am. Jour. Ob.*, Vol xi, p. 771.

8. Discussion on the Treatment of Retention of the Placenta after Abortion, by Drs. Pooley, Skene, Noeggerath, Thomas, Harrison and Mundé, in the *N. Y. Obst. Society*,—*Am. Jour. Obst.*, Vol. xi, p. 773.

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10. The Etiology, Pathological Anatomy and Clinical Features of Intra-Uterine Vegetations, Chronic Hyperplastic Endometritis, by R. Olshausen, *Archiv fur Gynecologie*, Vol. 8, No. 1.

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